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NORTHUMBERLAND & DURHAM  
MEDICAL SOCIETY.

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THURSDAY, NOVEMBER 8, 1883.

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CONTENTS.

PREVALENT DISEASES OF THE DISTRICT.

PATHOLOGICAL SPECIMENS.

DISCUSSION ON THE PATHOLOGY OF PNEUMONIA.

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# C. J. HEWLETT & SON,

(Late CREE CHURCH LANE),

## WHOLESALE DRUGGISTS,

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LONDON, E.C.

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# NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

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THE SECOND MONTHLY MEETING was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, November 8th, 1883—the President (Dr. Arnison) in the chair.

The following gentlemen were elected members of the Society :—

Thomas Proudfoot, M.B. Edin., Newbiggin-by-the-Sea.

Richard Brown, M.B., Blaydon.

— Hutchison, L.R.C.S., Newcastle.

The following gentlemen were proposed for election :—

James Drummond, M.D. Glasg., South Shields.

Percy Blumer, Sunderland.

J. Pearcey, L.R.C.P. Edin., Sunderland.

G. B. Craig, M.R.C.S., Willington-on-Tyne.

Chas. H. Milburn, M.B. Durh., County Hospital, Durham.

Charles George Maclagan, MB., C.M.

## DISCUSSION ON THE PREVALENT DISEASES OF THE DISTRICT.

Mr. HENRY E. ARMSTRONG forwarded the subjoined return of

*Admissions to and Death at the Newcastle Fever Hospital during  
the month of October, 1883.*

	Admissions.	Death.
Enteric Fever.....	5 .....	0
Typhus.....	1 .....	1
Scarlet Fever.....	1 .....	0
	—	—
Total.....	7	1

The last case of smallpox was discharged from the Smallpox Hospital on the 31st of August.

Dr. DRINKWATER said that small-pox was becoming more prevalent in Sunderland. The first case occurred in a child, aged  $4\frac{1}{2}$ , *not vaccinated*. It died shortly after the nature of the disease was discovered, at first having been mistaken by the parents for “water jags” (chicken pox). It was the child of Roman Catholic parents, and a “wake” was held at the funeral ceremony. This caused a further spread of the disease to many families. He had 22 cases, three of which were *unvaccinated*, and two of these died. *All the vaccinated recovered.*



Dr. PHILIPSON expressed the regret of Dr. Embleton at his inability to be present. He stated that an engagement had occurred which Dr. Embleton could not have altered, hence his absence. In the absence of Dr. Embleton, he (Dr. Philipson) formally moved the following resolution:—"That the members of the Northumberland and Durham Medical Society desire hereby cordially to express their unanimous opinion that the President and office-bearers of the Royal College of Physicians of London, by their having rescued from entire destruction the mortal remains of the illustrious Harvey, the discoverer of 'the circulation of the blood,' and by their reverent translation of those remains to a marble sarcophagus, in the Harvey Chapel in the Church of Hampstead, Essex, on the 18th of October last, have earned the lasting gratitude of the whole medical profession and that of the world in general; and that a copy of this resolution be forwarded to the President of the Royal College of Physicians of London by the Secretary." Dr. Philipson stated that he felt that the removal of the remains of the illustrious Harvey to the new resting place had been productive of one very satisfactory result. It had elicited from scholars of every class an expression of general sympathy and approbation. Nothing had been more gratifying than to note the tone of the leaders of public opinion in their expressions respecting the merits and claims of the illustrious discoverer of the circulation of the blood. Every writer had commented on a life of purity and independence without blame. Each writer had expressed admiration at the manner in which Harvey had borne adverse criticism and had overcome the troubles of opposition. Each had expressed wonder at his extreme modesty when he was receiving homage from his friends on account of the character of his discovery. Each age had extolled his faith in the future as to his discovery being sustained by the test of time, without fear of contradiction. After the interval of two-and-a-quarter centuries this discovery justly placed him now as the greatest anatomist that this country had ever produced. Dr. Philipson expressed his great regret at the absence of Dr. Embleton, feeling that that gentleman would have done the question more justice than he had done, especially so as the subject was so consonant with the feelings of that much-esteemed and revered gentleman.

Mr. S. W. BROADBENT said he had much pleasure in seconding the resolution, but could not add anything to the eloquent remarks of Dr. Philipson, who proposed the resolution so gracefully.

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## PATHOLOGICAL TRAY.

Dr. GOWANS showed specimens from a compound fracture of the skull. Johannes Hodenberg, æt 24, seaman, a Swedish Finn, was admitted into the Ingham Infirmary, South Shields, at 4.30 p.m., 6th September, from the ship "Western Ocean," suffering from compound fracture of skull. *History*: Patient is stated to have received a violent blow on the head from the "crank of the pump," two days previous to his admission. He was rendered insensible. The wound was stitched up by some one on board. He remained unconscious up to time of admission. *On admission*: Patient was unconscious; over the right temple, about two inches above the ear, was a lacerated wound; on removing the sutures a small quantity of decomposed blood, pus, and brain matter was discharged; with the finger in the wound no bone was felt, but a cavity, going right into the brain substance; through the skin the edge of bone surrounding the hole (which was as large as a half-crown piece) could be felt. *Treatment*: Patient was put to bed, given gr. vi. of calomel, and an ice-bag applied to the head. The wound was dressed with carbolized glycerine on lint and gauze bandage; low diet. *6th September, 8 p.m.*: Patient somewhat restless, no apparent paralysis, slight difficulty in swallowing; temp. 99.2 deg. *7th September*: Patient has passed a fairly good night; he is semi-conscious and does what he is told; there is now facial paralysis on the left side, no motor paralysis of limbs, but sensibility appears diminished in right leg; patient speaks somewhat thickly; urinates naturally; has had no motion of bowels. Ordered mist. sennæ Co. ℥ii. and enema of soap and water. *4 p.m.*: Dr. Gowans saw patient and removed with forceps a quadrangular piece of bone one inch by half-inch from beneath the tissues at back of wound; pulse fairly good; pupils respond to light; temp. 99 deg. *8th September*: Still in semi-conscious condition, asks intelligently for "drink of water;" facial paralysis less marked; apparent slight loss of power in left forearm; ordered ol. ricini, which acted freely; patient is able to get out of bed to night-commode, but is very giddy; towards night more restless. *10th September*: Continues very restless; no apparent muscular paralysis; considerable bleeding from wound; large clots forming; motor paralysis of left foot. *5 p.m.*: Skin dry and hot; pulse full; unconscious; over wound clot size of hen's egg; micturated in bed; breathing soon afterwards became stertorous; temp. 107 deg.; died 10 p.m. After death an examination of the wound was made; the fracture was found to be saucer-shaped; round the margin were four pieces of bone which had been driven in on the brain, being attached at the margin by periosteum; the wound penetrated to the right ventricle. A section was made



round the margin of the fracture and the piece of bone removed ; the fracture was found to be local and did not extend either to base or vertex ; the opening was quadrilateral, and measured  $2\frac{1}{16}$  in. by  $1\frac{1}{16}$  in. ; its greater diagonal was  $2\frac{1}{2}$  in. ; the membranes were deeply congested.

After recording the above notes, Dr. GOWANS said : The interest of this case, sir, is chiefly of a negative character. The wound to the brain was directly over the fissure of Rolando, and extensively implicated the part of the ascending frontal and parietal convolutions, which according to Ferrier govern the movements of the hand and arm. These, however, in this case, were not seriously affected.

Dr. GOWANS showed in addition two ovarian tumours, and said : These tumours, sir, I removed by double ovariectomy. The patient, a tall, bony woman, first consulted me at my house on the 23rd of December, last year. She stated that although she never had enjoyed robust health, still she had managed to pull through some very severe illnesses. Her age was 39 years, and she was the mother of four children, the youngest being aged seven. About seven months previous to her visit she observed that her abdomen was enlarging, which she attributed to pregnancy, but was surprised to find that she continued to menstruate regularly, and that there was no other symptom of pregnancy. The immediate cause of her consulting me was pain in her abdomen. On examination I discovered a solid tumour, situated to the left of the median line, and about the size of a  $4\frac{1}{2}$  months' pregnant uterus. A belladonna plaster was prescribed for relief from the pain, and I requested her to return in a few days, when her menstrual flow, which was present, had ceased. I did not see her again till March 14th, when I was requested to visit her at her home. I found that her health had greatly deteriorated ; she was emaciated, "facies ovariana" well-marked, great pain experienced on defecation, and at times in the abdomen. Her belly was distended so that she had difficulty in keeping the supine position, and it measured  $41\frac{1}{2}$  inches in circumference at the umbilicus. Percussion gave a dull note all over except at the flanks, which were clear. The abdominal veins were greatly enlarged. A vaginal examination revealed a semi-solid cyst packed down in the pelvic cavity, and presenting a rounded edge, within quarter-of-an-inch of the vaginal entrance. The uterus was in front of it, and measured  $3\frac{1}{2}$  inches. *Diagnosis*: A compound ovarian tumour, having solid portions, and also cysts of considerable size, with fluid contents, and very thin walls ; the cyst in the pelvis having few adhesions, but the main tumour having probably extensive adhesions. The diagnosis being confirmed by my friend,



Dr. Lambert, I operated on the 17th of April, in the presence of Drs. Lambert, Murphy, Rathborne, Drummond (of South Shields), and Lowes. The anæsthetic used was the "A.C.E." mixture, which answered admirably during a long operation. Full anti-septic precautions were adopted. An incision was made in the linea alba from the umbilicus to near the pubes. On opening the peritoneal cavity the tumour was found to have adhesions nearly all over. In breaking these down one of the thin-walled cysts gave way, and a considerable quantity of its fluid contents escaped. The tumour having been dragged forward by means of cyst forceps, the pedicle, which was of fair length and about the thickness of three fingers, was transfixed by Wells' blunt needle, and secured by a double ligature of carbolized silk. The cyst packed into the pelvic cavity was then found to be connected with the opposite ovary, and was quickly removed, as it had few attachments, and its pedicle was treated in a similar manner to the other one. Oozing from torn adhesions constituted the greatest difficulty of the operation, especially deep down in the cavity of the pelvis, where the bleeding points could hardly be seen. Considerable patience and a free application of the cautery at length overcame this. The peritoneum was thoroughly sponged, and the wound closed by silk sutures. At the end of the operation the patient was greatly collapsed, but by the evening reaction had set in, and she was perspiring profusely. I will not trouble you with the details of her progress. The wound healed by first intention. Vomiting and a tendency to high temperature caused anxiety for a few days, but she made a good recovery, being out of bed at the end of three weeks, and out of the house at the month's end. She went into the country for change of air, and returned fit for all the duties of her household. I would here gratefully acknowledge my indebtedness to Drs. Lambert and Murphy for their kind advice and able help during this somewhat formidable operation, and also to Dr. Lowes, Senior House Surgeon to the Ingham Infirmary, for the careful and skilful administration of the anæsthetic. The larger tumour measured 2 feet 10½ inches in circumference, and weighed about 30 pounds. The smaller one was about the size of a child's head at birth.

Dr. LAMBERT said : Through the kindness of Dr. Gowans he was present at this formidable operation. It was one that would have tried the nerve and coolness of the best operator, so many difficulties presented themselves. He considered that the case did great credit to Dr. Gowans as an operator, considering the operation occupied two hours and a quarter, and that, when the patient was removed to bed, she was more like a dead thing than any case he had ever seen.

Dr. MURPHY said : It so happened, Mr. President, that, within a



few days of Dr. Gowans' operation, I had the opportunity of seeing four ovariectomies. On the Friday I had a case, on the Sunday Dr. Lambert had one, Dr. Gowans did his on the Tuesday, and on the Thursday Dr. Drinkwater had a very interesting and successful operation. Now, of these four, mine was as favourable a case as one could reasonably expect, while the case which has been just related was one of the most formidable I have ever seen. When Dr. Gowans opened the abdomen he found an ovarian tumour which at a few points only was not adherent to the surrounding structures, and, had he been more concerned about his statistics than about his patient, he would have at once closed the wound and have called the operation not an ovariectomy but an exploratory incision, which fully confirmed his original diagnosis. Instead of doing so, he carefully separated each adhesion, removed the tumour, and then, with the greatest patience and perseverance, searched for bleeding points, turning over the omentum and intestines again and again, and exploring every portion of the abdomen, till, by means of ligature and cautery, all was secure, and not till then was the abdomen closed, having been open for two hours and a quarter. Dr. Gowans is to be equally congratulated on his decision to operate in such an evidently formidable case, on his determination to proceed when he found his opinion confirmed, as well as upon the success that rewarded his pluck.

Dr. OLIVER said : This half of a brain was removed from the body of a man who, for the last eight months, had been an inmate of this Infirmary. Aged 35, he had been in excellent health until three months before his admission, when he noticed he was losing his eyesight. He was a temperate man, and never had syphilis. When he first came under observation, he complained of pain in the head and of vomiting, the pain being referred to the vertex. There was neither loss of motion or sensation. He had lost control of his sphincters, however. At this time patient was able to walk about quite well, but the blindness was increasing. There was very marked neuro-retinitis with hæmorrhages into the retina. The latter, as time went on, were absorbed in great part, and the disc became extremely atrophied. About a month after his admission it was noticed that his gait was staggering, and that progression was a matter of extreme difficulty to him unless he was supported, patient exhibiting a marked tendency to fall to the right. When his eyes were closed he could not maintain the upright position. As the disease advanced patient became more and more unable to stand. He never lost the power of moving his limbs, which ultimately became extremely emaciated and rigid. Plantar reflex remained increased throughout his illness. Sensation was never interfered with until half-an-hour before his death, which was due to a convulsion. Patient retained consciousness



throughout. I had regarded his illness as dependent upon a lesion situated in the posterior part of the brain—the cerebellum in all probability. At the autopsy there was found tumour of the right gyrus fornicatus, which extended into the posterior part of the right corpus striatum—the corpora quadrigemina and the left lobe of the cerebellum. The tumour, evidently a glioma of an infiltrating character, had therefore very extensively diffused itself, if I may so speak, through brain tissue, and yet disturbance of equilibration was really the only symptom of importance. Disturbance of equilibrium and muscular inco-ordination are symptoms common to lesions of corpora quadrigemina and cerebellum, and in this case the probability is that they depended chiefly upon disease of the corpora quadrigemina; for, though the left lobe of the cerebellum was involved, it was evidently secondary. The case is interesting as showing to what extent the convolutions on the median aspect of the brain may be involved without giving rise to anything like what might be called “*localizing symptoms*.”

Dr. OLIVER, continuing, said: At our last meeting, Mr. Chairman, when making a few remarks on an interesting specimen of carcinoma and abscess of the liver, I stated that probably I would exhibit a specimen of malignant liver, in which I expected to meet with gall-stones as the associate of malignancy. That probability is now realised; and the argument I put forward, that malignant disease of the liver was so much more frequently associated with the presence of gall-stones than to be a mere coincidence, is substantiated—I do not say proved—by their association in this specimen. I bring the specimen forward, not simply because it shows the gall-bladder distended with calculi and cancerous nodules in the liver substance, but also because one can feel that when an exploring needle or a pin is driven into the gall-bladder, and impinges upon the calculi, it rebounds, just as a *sound* does off a stone in the bladder, only to a very much minor degree, and does not penetrate the calculus unknown to the finger of the examiner, as was maintained at our last meeting. Just as in urinary calculi there are degrees of hardness, so too with biliary calculi, some are hard, others are soft. I can with certainty affirm that those which are hard *can* be detected by means of the exploring needle. From a scientific point of view, therefore, I think the case of interest as clearing up a point on which there seemed to be some mystery. The whole of the left lobe of the liver has been converted into a malignant growth, which, from its hardness, I should say is schirrus. It is extremely dense, and offers great resistance to the passage of a needle. It was when the needle was deeply plunged into this mass that the fingers detected a sense of grating, not unlike that which small biliary calculi would



give, and which certainly biased us in our diagnosis of malignant disease of the gall-bladder. Of the history of the case there is little to say. It was a painless growth from the beginning. It was noticed a year before her admission into the Infirmary as a hard lump in the upper part of the right half of the abdomen. She never suffered from jaundice nor biliary colic, nor did she suffer from the dyspeptic troubles so frequently met with in malignant disease of the liver.

Dr. MURPHY said: This specimen is the terminal phalanx of the great toe, which I removed from a young lady, aged 25, on account of the exostosis which you see exists here, and which is a very typical example of the disease. My reason for showing it is to suggest that the safest way to deal with such cases is to amputate the whole phalanx, as has been done here; and to point out that the treatment recommended in the text-books on surgery, namely, to gouge out the growth, is quite inefficient, as the disease will undoubtedly return, and the partial amputation of the phalanx does not appear to have any advantage over its complete removal.—Here are the trachea and larynx of a child, æt three, after the operation of tracheotomy which I performed on a patient Dr. Ridley Dale kindly asked me to see with him. The operation was done under chloroform, and when the tube was introduced a large quantity of muco-purulent discharge and some false membrane were immediately coughed up; the breathing became almost normal, the marked cyanosis is quickly subsided, and the child, which had been quite unconscious for the preceding couple of hours, became quite sensible and took a little milk. Dr. Dale returned in two hours' time, and to his horror found the little thing sitting on a sofa playing with its toys, having only its shirt on. He naturally remonstrated forcibly with the mother, whose excuse was that the child had been fretting to get up and she could not refuse it. This sort of thing frequently happened, and we several times found the child up or in its mother's arms with but little covering on, and though for the first two days nothing could have been more favourable than the child's condition, subsequently, from exposure and neglect, pneumonia set in on the third day, and it gradually sank. The specimen shows that the glottis is completely stopped up and the larynx and trachea is lined with a thick membrane. I would add that in performing tracheotomy I prefer standing at the left side of the patient, as thus the incisions are conveniently made from below upwards, which is the safest method. I entirely agree with Mr. Holmes that the best place as a rule to open the trachea is above the isthmus of the thyroid, for it is probably as efficacious, and is much more easily and safely accomplished; as below the isthmus the depth of the trachea, with the normal arrangement of vessels—and in children under two the thymus gland add consider-



ably to the risks of the operation, to which must be added the frequency of abnormal arrangement of vessels, such as the left brachio-cephalic vein crossing the trachea well above the sternum, the left carotid arising from the innominate, and very frequently we meet with an inferior thyroid given off from the transverse portion of the arch of the aorta, &c., &c. Further, when one is not pressed for time, owing to the urgency of the dyspnœa, the slower one performs tracheotomy the better in my opinion; for by cautiously and slowly dividing the tissues down to the trachea, and drawing any vessels to the side, this operation can frequently be performed with but little bleeding, a matter of much moment; as though venous hæmorrhage generally stops soon after the tube is inserted, a quantity of the blood generally gets into the trachea and thence into the bronchial tubes before this is accomplished. For the insertion of the tube many ingenious devices have been invented, of which I prefer this dilator, that I had made some years ago; it is easy of introduction, dilates the incision fully, and above all, holds the trachea firmly without any risk of injuring it.

Dr. COLEY called attention to cases of membranous laryngitis produced by irritants, such as steam, as proof that membranous laryngitis is not necessarily due to diphtheria. He urged that tracheotomy, when possible, should be done early, so as to avoid the injury to the lungs from obstruction to respiration at the larynx.

Dr. NEWCOMBE said: My experience with regard to the operation of tracheotomy in croup is that its necessity depends upon the evidence of the stethoscope. If we find the small air-tubes of the lungs gorged with false membrane, the time for operation is past. To be of service it should be performed before this occurs. The operation is not difficult, but the entrance of the tube into the trachea is often rather obstructed on account of the great thickening from an adventitious membrane.

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## DISCUSSION ON THE PATHOLOGY OF PNEUMONIA.

Dr. GIBSON read a comprehensive and carefully-prepared paper on the "Pathology of Pneumonia," comparing the cardinal forms of the disease with each other in their anatomical changes, and in their representative manifestations during life. He pointed out the peculiarities of the pneumonic inflammation, which especially tended in the direction of pulmonary phthisis, and set forth distinctly the frequent interdependence of pneumonic and pleuritic inflammations.



At the conclusion of the reading the PRESIDENT remarked that the paper covered a large amount of ground, and requested Dr. Gibson to name some point or points in his paper upon which discussion should be taken.

In response to the President's request, Dr. GIBSON said that he had taken care to set forth in his thesis many points upon which he thought discussion could be advantageously raised; but if he were required to single out one of these, he would say that the pathological relationship between the fibrinous and the catarrhal forms of pneumonia would, in his opinion, be very suitable.

Dr. PHILIPSON congratulated the officials of the Society on the inauguration of the discussion. He complimented Dr. Gibson on the value of his paper, and on the able manner in which he had introduced the subject. He considered that the description of the anatomical character was quite incontrovertible. He gathered that the view of the reader was that the disease was a local one. In this he entirely disagreed. He regarded acute lobar pneumonia as a general disease, of which the pulmonary inflammation was the prominent local affection. The view that it was a strictly local affection of the lung, to which the pyrexia and other symptoms were secondary, was altogether untenable. The truth of the statement became obvious from a study of its natural history. The disease runs a typical course; the pyrexia bears no definite relation to the lung affection—it frequently precedes it by a considerable interval, and commonly disappears suddenly, and long before the resolution of the pulmonary consolidation. Respecting the exact nature of the disease, however, he was not able to speak definitely. By some observers it was maintained that, like the specific fevers, it was due to a specific cause. Pneumonia, whilst differing from these fevers in not being contagious, resembled them in the typical character of its clinical phenomena, and, to a less extent, of its local lesions. The changes in the lung occurring in pneumonia could not be induced by artificial injury of the organ, and it must therefore be admitted that there was something special in the inflammatory process. Again, in its treatment it was like specific fever—it was necessary to be guided by the same principles, the object being to endeavour to conduct the pneumonia to a favourable termination. Its progress could not be arrested, but it was possible to maintain the strength of the patient, and to modify those elements in the disease which tended to the destruction of life. As to the special character of pneumonia, and to its being a general disease, he contrasted it with typhus fever, and pointed out how the two diseases resembled each other in their mode of onset, progress, and termination. The pyrexial state in the two diseases he carefully described, and showed their analogy, both being attended with a morning remission and an evening exacerbation; both reaching a



high grade in a few hours subsequent to the outset; and both suddenly subsiding, on a fixed day, in the crisis, when a rapid improvement was observed in all the symptoms—in pneumonia the average duration being eight days, while in typhus fever the average duration was twenty-one days. The resemblance of the two diseases, therefore, was so marked that they might fittingly be spoken of as continued fever, with the local manifestation in the lung in pneumonia, and in the skin in typhus fever. The latter disease was highly contagious, while the former was either not contagious or only contagious under exceptional circumstances; and it was in this character that the main difference of the two diseases was manifested—were succeeded by sore throat and a degree of prostration out of all proportion to the severity of the local lesion. It was to diseases of this character that pneumonia exhibited the closest resemblance; and it was in this light that pneumonia was regarded as a general disease. The train of symptoms in pneumonia seemed to warrant the supposition that there was a period of dormancy, and that this state was changed into one of activity by an influence which was as yet shrouded in uncertainty.

Dr. OLIVER said, in thanking Dr. Gibson for opening the discussion on pneumonia, that it was a pity Dr. Gibson did not separate croupous from catarrhal pneumonia, for, if he understood the question aright, it was a discussion upon what really constitutes pneumonia. It was some information we wanted on the subject as to whether pneumonia was to be regarded simply as a local inflammation, the result of cold, or whether it was the localised expression of a constitutional state which might be regarded as specific. For that reason, therefore, he was glad that Dr. Philipson had raised the question, and raised it in such a way as to show that in most cases pneumonia really was a specific inflammation. If he (Dr. Oliver) expressed an opinion, it would be one leaning towards the specific nature of the disease. He confessed that within the last few years he had changed his opinion—that he now regarded pneumonia as a localised inflammation, the expression of a constitutional state, the lesion itself being the means whereby the *materies morbi* is eliminated from the system; and towards that many things pointed, as Dr. Philipson had shown. There was the decided rigor, the sudden rise of temperature—a rise that was maintained until the 7th, 8th, or 10th day, when it suddenly fell, the patient there and then feeling well, even though the signs of pneumonia existed in the chest. The temperature chart itself was so typically that of a constitutional fever that from it alone many could say the illness was pneumonia. However strongly he supported the specific nature of pneumonia, he yet believed that the lung, just as other organs in the body, became inflamed as the result of cold, giving rise to crepitation



and small mucous râles, without the marked dulness on percussion, and never running into anything like croupous pneumonia. These cases ended favourably in a few days. He had been frequently struck with the influence which chronic alcoholism had in altering the characteristics of pneumonia—how it tended to develop a state which is with difficulty separable from typhoid fever, and which, from the peculiar character of the nervous symptoms so developed, had been called by Niemeyer *typhoid pneumonia*. In such, owing to the disorganised functional activity of the liver, as the result of heavy drinking, the intestinal secretions were unhealthy, and consequently diarrhœa of an offensive nature early came on, which only tended to increase the difficulties of the diagnosis. With these remarks, he would wind up by saying that the real question at issue still remained unanswered, and that is, *What is pneumonia?* for until we had some general idea as to its etiology and general pathology we could scarcely discuss it.

Dr. GOWANS said : I feel diffident in responding to your call, sir, to address the meeting on the subject of pneumonia, because I have already occupied so much of your time. Dr. Gibson has with great ability expounded what may be considered the orthodox views of the profession on the subject of pneumonia. Dr. Philipson, however, appears to me to have broken up the more debatable ground, and which, perhaps, at present is of most interest. I desire to confine my remarks to that form of pneumonia which is usually termed “croupous,” and my observations have chiefly been made on boys between the ages of 10 and 16 years, at the Wellesley Hospital. The largest number of cases under treatment at one time was six. The disease commenced with a rigor and sudden rise in temperature, to about 104° Fh., with symptoms of severe fever. On the morning of the fourth day a spot of herpes appeared usually on the lip, but frequently on some other part of the body, and about the same time symptoms of lung engorgement were detected. On the evening of the fifth day a sudden deferescence occurred, and the patient was convalescent, or the temperature again rose, but not nearly so high as before, and on auscultating the chest, the physical signs of the later stages of pneumonia were found usually over an extended area. In private practice, although I have frequently observed the same form of disease in an isolated form, I cannot recall ever having more than one case at a time in a household. I also am inclined to the opinion that puerperal women are peculiarly prone to the disease. My feeling therefore is, with Dr. Philipson, to regard croupous pneumonia as a specific disease which runs a definite course, and that the lung mischief bears much the same relation to the disease that the throat affection in scarlet fever does to that disease ; also, that it occurs in an epidemic form, and is probably not contagious.



Dr. COLEY said he admitted the extreme probability that in some cases pneumonia is the local expression of a general disease, possibly specific in character, but urged that the same pathology is not necessarily to be ascribed to all. Just as in the larynx most cases of croupous inflammation were due to a general disease, diphtheria—but some were due to the action of an irritant, such as hot steam, so in the lungs most cases of croupous pneumonia might be due to a general disease, while others were caused by local irritation. Indeed the action of chlorine had been observed to produce pneumonia. The regular course of the disease, and the subsidence of pyrexia before the complete disappearance of local morbid conditions, could not be held to prove much either way, for the same might be said of ordinary local inflammations.

Dr. DIXON said : The morbid processes concerned in the production of the disease called pneumonia are well understood, and can scarcely give rise to discussion. The debatable points are those having reference to the etiology and nature of the disease. As these questions cannot be settled by individual experience, but only through the aid of extensive general observations, it would be more profitable in the present discussion to refer to the recently-published results of the inquiry of the Collective Investigation Committee of the British Medical Association into these topics. These results are very interesting, and are based upon the records of 350 cases of acute pneumonia. The investigation is not yet complete, but as far as it has already gone it is valuable and instructive. This record of the Collective Investigation Committee so far shows :—

1st. That general insanitary surroundings are not so marked in their influence over pneumonia as a combination of cold and wet.

2nd. That facts are against any theory of direct connection between pneumonia and prevalent infectious diseases. Erysipelas was often found to prevail in the same district, but was not in actual juxta-position with pneumonia, thus favouring the conclusion that these diseases were independent results of similar meteorological conditions. Tonsillitis was more prevalent along with pneumonia than any other acute inflammation.

3rd. The evidence is against the theory of the tendency to this disease being hereditary, and it is in favour of one attack predisposing to another. Acute rheumatism was rarely noticed as preceding pneumonia.

4th. The crisis was more often absent than present. The seventh day was most frequently the critical day. The part of the lung affected seems to have no fixed relation to the critical or non-critical form of the disease.

5th. That the data are not yet sufficient to warrant the adoption of any theory as to the communicability of pneumonia, nor to



support the doctrine that this disease is a specific fever with a local manifestation.

6th. The question of pneumonia being truly epidemic has not yet been decided by the facts brought out in this investigation.

As the hour for terminating the meeting had arrived, the PRESIDENT called upon Dr. Gibson to reply, and to close the discussion.

Dr. GIBSON said that his reply need not detain the meeting one minute, inasmuch as his paper had not been the subject of debate. Dr. Gibson explained that he had been requested by the Society to read a paper upon "The Pathology of Pneumonia," in order to initiate a discussion upon that subject. He had responded to this request by reading the thesis which the members of the Society had just heard read. Doubtless pneumonia had many aspects which were of deep interest to the physician and to the pathologist, but the points of view which had been set forth in the discussion were for the most part matters of speculation, and of speculation only. They had as a matter of course been passed in review in the preparation of Dr. Gibson's thesis, but the exigencies of the Society precluded him from introducing any of them into it. It was, indeed, unfortunate under these circumstances that members had not attempted a commentary within the limits prescribed by the Society for the evening's discussion. He had no desire himself to comment upon the discussion at large; but, with regard to the assumed specific febrile quality of fibrinous pneumonia, he ought to say that he had neither seen, nor heard, nor read anything which could lead him to recognise it. Doubtless pneumonia may have an etiology which cannot always be easily traced, and its course may from time to time appear to be abnormal; but the exciting cause of the malady was commonly very apparent, and the local effects of that cause were not less so. Then the assumption that pneumonia was a general disease, and only incidentally a local one, demands affirmative proof, the minutest item of which had not yet been supplied so far as he was aware.

The SECRETARY (Dr. Drummond) called the attention of members to the fact that the discussion had been, of necessity, greatly curtailed, and therefore robbed, in a measure, of its usefulness, owing to the want of time. He suggested that an hour should be fixed at which the next (surgical) discussion should commence.

Dr. PHILIPSON agreed with the Secretary, and proposed a quarter-past seven.













# THE VERDICT.

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